MCHCOM.com MCH/CSHCN Director Webcast – March 2003

>> Welcome, everybody.
I'm Peter van Dyck, Director of the Maternal and Child Health Bureau.
We're broadcasting from the Parklawn building here in Rockville, Maryland which is one of the bimonthly Internet broadcast.
These broadcasts will include slide presentations, on-line polls, websites and allow us to pose realtime questions to the speakers through our message center.
We'll try a video today in addition to the usual power point slides.
Chris DeGraw, the Acting Deputy Director will join me and serve as a liaison between you and me.
He'll field your questions and show the results of polls when we do polls.
And make sure things keep moving here.
You can submit questions any time during the broadcast and I encourage you to do so.

Look at the right side of the screen.
I think most of you know how to do this.
You see the message center there.
Just submit a question or comment, type your name and state in the little box titled subject.
And then beneath that subject box there is another box where you can enter your question.
Once you type in your question, punch the send button and that question will come to us over the computer and if we deem it appropriate and easy to answer we'll probably answer it.
Otherwise, we may not.
I think you know how to synchronize the slides now on the flip page.
Sooner or later those numbers that you see on your screen are in seconds.
I think you know this by now.
So without further adieu we'll begin.
We have an exciting lineup.
Cassie will talk to us for a minute about the project officer transition for the MCH block grant from the regions to the central office.
Mary from the Office of Data & Information Management will talk to us about international perspectives on adolescent violence and I'll update you on Afghanistan with a few slides and a quick video.
Since I missed AMCHP and didn't get a chance to talk to you there and let you know when I was doing while you were having fun at AMCHP.
Cassie, we'll begin with you, welcome.

>> CASSIE LAUVER: Thank you, Peter.
I just wanted to really take a few minutes to update and review a letter that I'm sure most of you have received, at least from Dr. van Dyck that went out last month about the transition of responsibilities in the field offices.

And as you may or may not know, in the January 7th, I believe, federal register there was an announcement relative to changes in field office -- actually, it was addressed a number of things.
Probably the most relevant thing for the MCH staff I believe has to do with the transition of the field offices.
And one of the -- one of the new things coming from that federal register notice is the transition of a number of the duties from the field office back to central office staff.
One of those includes the responsibility and oversight or the project officer responsibility for the MCH block grant as well as the SSDI grant back to central office.
And as of March 17, which was just this last Monday, St. Patrick's Day, the responsibilities officially transferred for the block grant, for the MCH block grant, to the central office.
And part of the power points that I did send out and we also handed out at AMCHP, although I know not all states were able to make it to the meeting, included the individuals in the division of state and community health that would have project officer responsibilities by region.
And actually this is something that we began two years ago in the division.
That was to assign individuals from the division to specific regions so staff could become more familiar with states and with the particular region and that there would be continuity for the states, particularly around the time of block grant review.
So hopefully you have as part of the Power Points, and I'll go over these as well for contacts in our field offices, we have Audrey, who is the project officer in region one.
Carol -- Jeff who is the project officer in region two.
Carol, region three.
Mary Beth, region four.
Jeff region five.
I'll be project officer for region six.
Jeff for region seven.
He's the winner with at least three regions relatives to staff distribution.
Audrey is region eight, I'm number nine and Mary Beth is region ten.
You have contact with numbers and e-mail address.
Oftentimes it is the e-mail that will get the quicker response when you need to contact someone here.

There are many responsibilities that the regional office staff had that were probably more in tune because they were actually out in the region and were easier for those staff to be able to work with than perhaps we can at central office.
But I think one thing that will be continuing to work on, it is a work in progress, and that's the communication between central office and regional office staff and we'll be working with Jim McCray in the office of performance review.
The new name for the office of field operation and his staff trying to work out a smooth transition.
So the regional staff will continue to have a role with states and communities and other grants that come from HRSA, and finally to say that Dr. C.J. Wellington will be the project officer in all states.
His phone number and e-mail address is also included.

Feel free to contact us.
We know that -- we anticipate that there may be frequent contact, at least as we're working towards the block grant application process with a new block grant and a new web-based submission process.
Contact us and we'll get back to you.
Thanks.

>> PETER VAN DYCK: Thanks, Cassie.
Remember, you can type in your questions and we will review those as the session moves on.
And if you have them, please type them in and send them to us.
Next we have Mary from the Office of Data & Information Management is going to share with us her findings on international perspectives on adolescent violence.
Mary.

>> MARY OVERPECK: Thank you, Dr. van Dyck.
I'm going to demonstrate a little bit about what we can learn about ourselves by putting ourselves in the international perspective.
Chris, if you'll bring my slides up.
>> They're up.
>> They can see them.
I can't see them.
Oh, good.
Well, essentially international perspectives on international violence.
We have been the principal investigators and the data have also been accumulated through Lois at the National Center for Health Statistics and Pat Moyer who helped us get the data together.
The data sources, they primarily come from the world health organization statistics office and also have the international collaborative effort on injury statistics for mortality.
We're using the latest data we can get from the world health organization that will provide us comparability.
The data for our subset of countries that are participating on injury statistics are shown to describe how deaths occurred.
They're not -- the description are not available for most countries.

We only have a few countries.
But these countries were participating in a study to see what we can do to improve our data and provided the special data sets to us.
They also -- the data was collected during the transition from ICB9 to ICB10.
There shouldn't be any problems in comparability.
Our non-fatal data source is the WHO study of health behavior in school children.
A 1997-1998 school year survey.
Non-fatal data on describing the countries or regions who participated in the study which is co-sponsored by the Maternal and Child Health Bureau.
The injury mortality rates are for ages 15 to 19 and our rates per 100,000 adolescents.

The data provided to the world health organization from each country, according to the ICD9 or 10.
The comparability at the level I'm showing you shouldn't be compromised.
We used about ten years of data from each country to limit the variability in rates due to small numbers of deaths in some countries.
Because of the ten-year averages recent changes may not be reflected, particular here in the United States.

More recent data are available from the centers for disease control on their website.
The intent in the violent deaths is classified as either unintentional, suicide, homicide, undetermined intent or other.
Other includes civil and police actions and acts of war.
Now, I'm going to spend some time on this slide.
I know you can't read all the country names in the video cast and I'll walk you through the most important points.
It represents the injury mortality rates at ages 15 to 19 in about 26 European countries, North America and Greenland.
The first point is the U.S. is among the top five countries for adolescent injuries fatalities.
And parts of the former Soviet republic.
These are the most extreme bars on the top of the charge.
The colors describe intent.
The first color is for unintentional injury.
The second is for suicide.
Next is homicide, followed by deaths with undetermined intent and other.
The unintentional injuries represent the most traumatic deaths in all countries.
Among intentional dates.
Suicide rates are higher in all countries than homicide rates except the U.S.
Our greatest concern is that the U.S. has the highest homicide rate.
We do have the leading rate for homicides.
However, the U.S. and Canada both have fairly high suicide rates at ages 15 to 19 compared to most other countries.
And we do know that suicide rates tend to be underreported in all the country.
Various issues, including the determination it was a suicide or the probability that they will put that on the death certificate.
When we consider what the most important issues are for adolescents, we really need to address suicide in the United States as well as in the other countries.
It is a most significant problem for our kids.

I'm going to talk about how the kids died.
By looking at the mechanism.
The mechanism could be firearms, cutting or piercing usually with knives or by suffocation.
The suffocation would include hanging.
For violent deaths I'm focusing on the mechanism of death only for homicide and suicide.

The data on the mechanism are from a National Center for Health Statistics advanced data report that was co-authored by Lois Fingerhut and they represent over a number of years.
Now, let's look at homicide.
The U.S. is shown at the bottom bar.
Most obvious, firearms contribute to the largest proportion of all the very high homicide rates.
Far greater than any other country.
Homicide rates from cutting and piercing, usually knives, are about comparable in the U.S. and Scotland and less in other countries.

Again, it should be noted that U.S. data don't include the latest statistics available from CDC.
For the U.S. I would call particular attention to a more recent report on injury fatalities that shows that firearm deaths have been decreasing over the last few years in the United States.
Let's look at the mechanism of suicide.
The mechanism for committing suicides also shows firearms as the major mechanism in the United States.
Firearms are the first color on the bar.
Norway also shows high rates of use of firearms for suicide, as does New Zealand, Israel, France, Canada and Australia.
However, suffocation, probably hanging and use of plastic bags, is the most common form in New Zealand, Canada and France.
I'm going to speculate a little bit about the issue about the mechanism.
I don't have to speculate, actually.
One of the issues about our very high suicide rates is probably the lethal things they have for them to use.
If they don't have guns in the home they're less likely to use them.
It's -- a gun is more efficient than any other means.
Now we're going to look at the non-fatal behaviors.
For that data, again I'm talking it from the study of health behavior in school-aged children.
It includes nationally represented in surveys of 11, 13 and 15-year-old youth in 29 countries.
It's based on their self-reports in school-based surveys.
Actually, it's -- it includes 125 respondents.
95 and in terms of looking at significant differences you can assume that if the countries are different by about 2 1/2% in each country then they're significantly different from another country.
The variables that we're looking at for all ages includes fighting, war -- other health-related and risk behaviors.
School, family and peer factors.
Every country collected data on bullying behavior.
The questions of fighting and weapon carrying were asked in fewer countries.
All countries asked how safe students felt at school.

The bullying definition is an commonly accepted definition used among researchers and prevention programs.
The way it's stated is -- we asked the kids to respond to, we say a student a being bullied when another student or group of students say or do nasty or unpleasant things to him or her.
It is also bullying when the student is teased repeatedly in a way he or she doesn't like.
But it is not bullying when two students of about the same strength quarrel or fight.
And the key factor is -- here is a power difference between the students.
The students, looking first at the bullying slide the students were first asked how often have you been bullied in school this term?
This slide shows the percent of 15-year-olds who said they had been bullied more than once or twice in the last term.
In contrast to deaths, students in the U.S. were no more likely to have been bullied than in the majority of other countries.
The last color on the bar is for those who were bullied at least once a week or more often.
The more extreme patterns of bullying.
The percent of U.S. 15-year-olds were who bullied more than once a week was not as high as in the most extreme countries.
But it was still higher than in the countries with the lowest overall rates of bullying.

On the next slide we're looking at the students who bullied others.
The students were asked how often they bullied other students.
Again, U.S. students were no more likely to bully others than in most other countries.
However, the proportion who bullied others more than once a week was higher than in countries with the lowest rates.
Then we asked students how likely they were to feel safe at school.
And this was asked in all countries.
The U.S. kids were just about as likely to feel safe as school as in most other countries overall.
But, students who sometimes or never felt -- who rarely or never felt safe at school represented one-third of U.S. students.
This means one-third of the students who go to school say, we never really feel safe in this setting.
Which is -- represents about one-third of the students which is comparable to the proportion of students who often feel safe but not always and then another third of students said they always feel safe.
So we need to address the issues about how they feel about going to school.
Other studies have shown that students do not attend school because they're afraid to go.
Now we'll look at physical fighting.
Only a few countries in this study asked about physical fighting.
It's what we have the data for.
Estonia, Israel, Portugal, republic of Ireland, Sweden and the United States.

The U.S. is shown on the last bar on the chart.
Our kids are no more likely to fight than in any of the countries shown.
The only country with significantly higher rates of public was Ireland.
This is for 15-year-olds.
Actually, the kids who are 13 years old are more likely to fight more frequently than 15-year-olds.
In the other countries 5% of the kids fought four or more times during the past year.
The last time you were in a physical fight, with whom did you fight?
They all were most likely to report that they fought with their friends.
After that, they were most likely to fight with their family members.
The lowest proportion to fight was with strangers.
We then asked the kids, during the past 30 days, on how many days did you carry a weapon such as a gun, knife or club for self-defense?
Only seven countries asked questions about the weapon carrying and the question includes either guns, knives or clubs, all grouped together.
Because the other countries felt the response rates would be so low they would be unreliable if they broke guns out separately.
We're asking about any weapons.
This is comparable to one of the questions on the survey.
In relation to fatality data countries did not separate the guns out.
More than 85% of kids do not carry any weapons for self-defense.
U.S. kids are no more likely to carry weapons than kids in other countries.
Finally because of our concern about violence and its relationship to homicides, we put together a set of those countries that collected information on fighting and homicides among 15 to 19-year-old.
For the 16 countries that asked about fighting.
U.S. kids were no more likely to fight than any other country.

When you compare the fatality rates among these countries.
The U.S. homicide rates at age 15-19 were twice as high as those in Estonia but exceeded the other countries by almost 20 times.
Estonia is one of the former Soviet republic countries.
In summary, the primary difference between fatality rates among U.S. and other countries is the homicide rates.
However, we really need to focus on the very high rates we have from suicide in our countries and other countries for adolescents.
It is, in some states, it is almost a leading cause of death.
And both the center for disease control violence center gives you the state and county data on this.
In some states suicide certainly exceeds homicide as the leading cause of death.
So in terms of focusing in on those issues I think we have a lot of work to do.
The behavior data indicates that U.S. adolescents are no more violent than those in other countries.
That is probably because the difference in the homicide rates and between us and the other countries is probably because guns are more likely to be involved than are the other mechanisms by which kids either kill others or themselves.

And wanted to talk a little bit about the comparability for the fatal and non-fatal behavior.
For most of the countries the fatality rates had to be grouped for more than one year because of the low number of fatalities.
The violent injury deaths are more likely to occur in older adolescents than younger youth.
Basically this presentation was a very fast, simple overview.
A number of factors are involved in different types of violence.
An excellent presentation with studies on youth violence may be found in the surgeon general's report on youth violence and for suicide, there is a fairly recent national report that was done collaboratively by a number of the federal agencies that proposed a national strategy to address suicide.
It was published by the Department of Health and Human Services in 2001.
Both reports thoroughly discuss what we know and the approaches to prevention, I would highly recommend we take a look at them.

>> PETER VAN DYCK: Good.
Thank you very much, Mary.
Chris, are there questions for either Cassie or Mary?

>> CHRIS DeGRAW: We have one question.
Comes from Iowa.
The question is, how does this data look when controlling for socioeconomic factors.

>> MARY OVERPECK: On death certificates we don't have any information with the economic factors.
Urban and rural data are available in the CDC's data and I'll give you a little speculation in terms of what we've looked at.
In the rural areas, the suicide rates are very, very high.
In the -- the homicide rates, California is one of the examples that I've seen recently in looking at the impact of homicide and suicide.
Suicide would be a data cause of death for northern California.
Homicide in southern California.
They represent urban areas but different patterns of behavior among the kids.
And I think that is again a certain amount of access to the weapons and that may be an issue in the rural areas as well.

>> Any other questions?
>> That's all for now.

>> PETER VAN DYCK: Thank you, Mary.
And again, any of you can type questions in for either Cassie, Mary or myself, for that matter.
You can even type a question that is not related to a presentation if you're dying to know it.

Don't be bashful about typing in questions.

I'm going to talk about Afghanistan for a few minutes now.
As some of you know, I just returned from a second trip to Afghanistan.
I was there for a little over a week in December and I was there for a little over a week just a week ago.
And just came home about the same time the AMCHP meeting was ending.
Secretary Thompson visited Afghanistan in October last year and he was very moved by the maternal mortality and the infant mortality that he saw there.

There are some preliminary studies from CDC that show that the maternal mortality in the rural areas is the highest ever recorded in the world, around 6,800 per 100,000 women.
Here the maternal mortality is around 15.
The infant death rate is in the range of 160, 170 or so.
Of course, those of you who know the rate in the United States, it's 7 or 6.9.
Clearly the maternal and infant mortality rates are high and the level of care is really appalling.
So being moved by that, by this direct visit, the secretary thought that the department had some unique capabilities.
One of those capabilities was perhaps providing a teaching clinic in one of the large hospitals in Afghanistan.

And so he began to explore that idea with the Department of Defense.
And the Department of Defense, you may ask why?
And that is because they have a large civil humanitarian arm now that is working on reconstruction in Afghanistan.
And this is the Department of Defense folks, but they have a function, and that function is entirely rebuilding and restructuring and remodeling wells, schools, roads, bridges, hospitals, and trying to improve the infrastructure and the life of the people in Afghanistan.
I think you'll see more of that fairly soon in Iraq as well.
So this is an important contribution that the Department of Defense can make in these countries.

Well, the Department of Defense was interested in partnering and with the ministry of health and the embassy in Afghanistan, a hospital was chosen.
It happens to be the only women's hospital in Afghanistan and a large women's hospital.
And the Department of Defense agreed to remodel the hospital and the Department of Health and Human Services agreed to provide faculty to improve the skills of obstetricians and gynecologists primarily, to provide long-term training for the obstetrical residents in that hospital so within two or three years these physicians would be better able to care for Afghan people and something left behind by this intervention.
I was asked to lead these teams, which kind of puts me in a position of having to be responsible for making sure this works.
And so I'll go through a few slides and show you a few pictures after this second visit.

The goals that the secretary has, and, in fact, the partnership have, are to demonstrate ongoing commitment of U.S. reconstruction efforts to the quasi-government to provide high quality health care to the Afghan people.
To train local health care workers in modern medicine.
And to provide a vehicle for ex patriot Afghan health workers to return to Afghanistan.

There are a large number of Afghan physicians in the United States, Canada, and other countries who are anxious to return home if they have a vehicle for doing that.
Partnerships clearly I've talked about the Department of Defense, USA-ID is a major partner.
The Department of state and we in the Department of Health and Human Services, and many of the Department of Health and Human Services, NIH, CDC and others.
The purpose of this particular visit, this second visit, was to assess the progress for a model teaching clinic for physicians, as well as other health professionals in Kabul.
And the secretary also committed to expanding this teaching clinic model to four Cities outside of Kabul over the next year.
So all the physicians throughout Afghanistan clearly cannot come into Kabul for an extended period of time.
So if you can bring the teaching clinic or bring faculty to these four Cities outside Kabul provides a better opportunity to train these physicians and health care workers as well.
Our purpose was to discuss these priorities with the Ministry of Health and the embassy.
We don't make a move without getting permission from the Ministry of Health to obtain or find the locations for clinics outside of Kabul.
This clearly has security implications.
To obtain approval for the clinics in the expansion plan in the ministry and work with partners on the ground.
There are others on the ground in Afghanistan already providing help.

The next slide is a picture.
This happens to be us meeting with the president of the Kabul Medical Institute and head of surgery for the Kabul Medical Institute.
The president is the man in the middle next to me.
The person on the other side of me is the director or the chief of surgery for the Kabul Medical Institute.
For your information, in a country the size of Afghanistan, there are 5,000 students in the medical institute, which is, I think, just unbelievable and that number clearly needs to be whittled down to get the most skilled to graduation.
The next picture shows our small team meeting with the MCH director.
The MCH director is a very bright-eyed, very bright woman pediatrician who began about five or six months ago and has a lot of wonderful plans for the country.
During these visits we meet with a lot of people to try to gain partnerships and partnership potential for what we want to do.

Now, just a couple things about the hospital.
It's a women's hospital.

What I mean by women's hospital, only women are admitted but it is not just deliveries or gynecology, it is other services for women as well.
So general surgery, ENT, internal medicine, dermatology.
So it is the only general-purpose women's hospital in Afghanistan.
They have about 40 deliveries a day, around 13,000 per year.
I think that is increasing as the population in Kabul increases as refugees return.
And five C-sections a day.
I'm sure that rate will go up significantly as our faculty gets on the ground.
They do eight other surgeries per day and they have at least with their relative primitive record keeping system, know of about 500 women with preeclampsia, another with placental PREVIA and fetal deaths each year.

400 patients come to the hospital every day and are screened for admission.
It's around a 300-bed hospital.
92 physicians on the staff.
About 56 of those 92 physicians are obstetricians.
Or obstetricians in training.
About 13 are really full-fledged obstetricians and 43 are residents in training.
About 35 are first year obstetrical residents.
You can see the level of skill and expertise in the hospital.
As far as the attendings, their latest continuing education courses or refresher courses in obstetrics occurred 23 years ago just before the Russian invasion.
So these folks have really not had refresher courses for a long period of time in any medical specialty.
23 nurse-midwives practicing at the hospital and the Department of Defense is doing a physical remodeling of the hospital that should be done by the end of March or the first week in April.

Now, the next is a picture.
This is the entrance to the hospital, which looks like an alleyway.
You see the men standing here.
That is because the men aren't admitted into the hospital grounds because it's a women's hospital.
So these are the men who accompany the women to this entrance point to the hospital and then pass the women on through the gate, basically, and wait for them to come out again if they are not admitted.
The next picture shows, looking back at that entrance from the inside, now you can see the men's backs in the distance part of the picture and the women in the foreground who are waiting along the walls just along the walls of this alleyway.
That's the waiting room.
For examination and screening to see if they need to be entered into the hospital.
The next picture shows the obstetrical C-section suite.
The equipment is quite primitive.
This is an OB surgical nurse in the picture.
And one of the things that we're going to have to do is refurbish the equipment so it becomes modern so we can teach modern medicine in this hospital.

The next is a shot of a nursery.
There are about five isolettes.
This one has three babies in it.
One set of twins in the foreground and another baby from another mother on the left.
I guess this is efficiency in the use of equipment.

There are no sick babies at this hospital.
These -- because babies all just stay with the mother in the bed, all the babies breast feed.
If the baby is slightly small or needs a little warmth in between breast feedings they come to the nursery room and are put in the isolette.
I do have a video that I shot and I would like to show you this video now.
It's a little tour of the hospital.
It is in the middle of the remodeling.
You can get a feel for how it is going to look.
What you don't get a feel for is how awful it looked before.
Don't be too disappointed at the dirt around or what looks like dirt around.
It is dirt.
But it will be cleaned up as soon as the remodeling is done.
We start by entering through this alleyway I just showed you in the still pictures.
And then when we come back from the video I'll show you a few more pictures and tell you where we're going.
Could we have the video, please?

>> VIDEO, NARRATED BY PETER VAN DYCK: This is the entrance to the OB ward.
The illustrious crew ready to go in.
Going in for an inspection of the hospital.
This is the first floor where we just came in the door.
This is the obstetrical wing that begins here at the entrance with -- With delivery and it progresses down this hallway to the C-section unit.
So on each side are regular rooms.
And behind these doors are the C-section suites.
This is the recovery room.
These rooms have been painted and cleaned up.
There is a sink in each room which has been installed with new plumbing.
Each room now has a heater to provide warmth.
It is thermostatically controlled.
This is walking down the opposite hallway in the other direction.
This is down where the delivery rooms, the labor rooms and the nursery are.
This is the back room at the beginning of the delivery room.
There is a new installed sink and mirror.
You can see the water heater up above which is newly installed.
And then a shower that the women can use.
And you also notice that all the windows have been repaired and there is new glass in the windows.

Then there is a room used for D & C, a small room with a couple of the old operating tables.
And as you walk through there, we come into the delivery suite and there are two rooms in this delivery suite.
One room has four beds, or will have four beds, and you can see what that looks like.
And then if we walk into the next room we have a second delivery suite and there are two new delivery beds here.
These were donated by a UNSPA that represent new equipment for this delivery room.
Also in the delivery room is a newly-installed air conditioner.

The surgical suites and some of these rooms have newly installed air conditioners.
This is a room across the hall from delivery where the women come after they've delivered.

Walk out onto the courtyard.
It's very large.
New heaters newly installed.
And fresh paint.
This is the central stairway for the second floor.
Look at the pretty tile work.
It's quite open.
You walk from one wing to this open stairway area.
There are nurses' stations around this area.

Down into the general surgical in-patient wards.
And if you follow around you can see how this is an open stairway that goes down to the first floor.
Where the OB and gynecology stations are.
So this is the entrance we went into when we began the tour of the hospital.
This is looking back out that entrance.
This is the main building and the OB and general surgical are all in this main building.
By looking at the side of building two, building two has dermatology and internal medicine combined on those two floors.
We'll walk over in this direction in front of the truck and we'll come to the two other buildings which make up the rest of the hospital complex.

So this is the entrance to the building two we were just looking at and if we go just to the left of that into this main courtyard you can see our new escort.
This is the door where the Japanese are building the out-patient facility, the screening.
And as you walk past our escort vehicles here, As we walk past these escort vehicles you can see a head.
The front of the L-wing of the building.
The lower part is the dining rooms and the kitchen.
And the upstairs that is just being rebuilt or completely newly built are the kindergarten rooms.
There are five kindergarten rooms up there for the children of the staff.

Nurses, physicians, everybody at the hospital.

As we progress back to the left here we have medical records and administrative offices, family planning offices are all in this building which begin at the out-patient clinic and then again beginning at the dining rooms and the kindergarten, you can see that that building extends on the top five rooms down which are -- which is the newly, completely newly constructed kindergarten.
And dining room area for staff clear down to the kitchen which is on the end on the main floor where the persons coming down the ladder.
That is the kitchen both for the staff, kindergarten and for hospital patients.

>> So this is the crew that is escorting us around the city these days.
Wonder full crew, wonderful, people.
The wonderful, modern escort vehicles.
Wonderful.

>> So you had an idea of what the hospital looks like.
It was closed to patients, obviously, during this remodeling which is creating great pressure on the other delivery hospital in the city which is now delivering 150 babies a day.
Clearly, establishing a teaching clinic in a hospital like this would be difficult in the United States, let alone in Afghanistan.
There is nobody else in Afghanistan training obstetricians or training physicians in anything other than emergency care.
So this is a clear, unmet need in Afghanistan.
The ministry of health agrees that this is an appropriate thing to do, as does the embassy and the physicians themselves are interested in having refresher courses.

Clearly there is a tremendous need in establishing infrastructure.
The drugs at the hospital are very spotty.
The X-ray, there is one X-ray machine which is broken most of the time.
There is one sonograph that isn't working at the present time.
In the lab there isn't even a microscope.
There are a few reagents to do a few tests.
No microbiology at all so no cultures can be done.
How do you practice modern medicine or refresh people in modern medicine without these kinds of at least some basic laboratory and pharmacy and X-ray skills?
The answer is, you really don't.
It becomes our responsibility to purchase equipment, find donated equipment to get a good formula to make sure the machinery works, to make sure it maintains.
That there is somebody to maintain it and to make sure training occurs for the staff on how to use it.
These are major responsibilities that we have to deal with.

As far as the training needs, what we've determined is that the first thing we'll do is training the 10 to 13 attending OB's with about a three-month refresher course.

They're very anxious to have this to try to upgrade their skills and they practice -- they deliver a lot of babies every day.
So we feel that we can upgrade their skills fairly quickly with people on the ground.
The long-term post graduate need will begin after the first three months and continue for two to three years training residents that are in the pipeline of this hospital to help them become well skilled, highly skilled obstetricians.
Our other responsibility clearly is to recruit faculty.
We feel there needs to be a faculty of four or five people on the ground in Kabul at this hospital at all times.
Probably the best mix would be two obstetricians, an anesthesiologist and midwife.
A family practice and faculty as well.

We would like to faculty to stay for three months at a time and rotate the faculty for three months every two to three years.
Clearly recruiting faculty means you have to answer security needs.
You have to help people feel comfortable there.
We need transportation, translation, food, e-mail access, phone access, teaching equipment, LCD projectors, computers, Xeroxes, all things that now are not at that hospital.
And so even what seems simple here is very difficult there.
The secretary has given us a time frame.
He said I want you to begin six months from about five months ago.
Six months means the end of April.
So we are trying to begin the teaching clinic at the hospital, have the equipment in place and the faculty in place and in Kabul, the first set, so we can begin by the end of April.

We've had three committees working on this.
I don't need to go into that.
Clearly there are many challenges.
Recruitment, equipment, lodging and security and then, of course, we have to think about in the back of our minds always this expansion to other sites where the hospitals are in the same condition as this hospital is.
Inserting a teaching clinic into those hospitals.
The next slide, I think the rest of the slides are pictures.
I do want to show you a couple here because the problems aren't over yet.
On this slide you see a picture of Kabul.
And then you see the four other Cities that we are going to over the next year.
In the west HORAT and probably from watching the TV or reading the newspapers you're familiar with these Cities.
In the north Mazar-i-Sharif, in the east Jalalabad and in the south Kandahar, these cities all you read about from time to time with skirmishes but there is a U.S. military presence in each of these cities and so there is security.
They tend to be relatively safe.
Everything is relative and you clearly saw our security force in that video that always traveled with us.

Now, one of the things I hadn't seen before was the Children's Hospital.
I had mentioned that this women's hospital does not keep sick babies.
So all those sick babies get referred somewhere.
They get referred to the Children's Hospital.
And it's the only hospital of that level in Kabul, actually in Afghanistan.
I didn't have time to see it the first week I was there in December but saw it the second week.
What I'll show you are some pictures of the sick nursery in the Children's Hospital.
This was disappointing to me, because we're going to spend all this time improving obstetrical care and trying to get good babies, of which we won't always be successful but we'll have some sick babies.
All those sick babies will get referred to this sick nursery.
The conditions here were less than encouraging.
So we have another responsibility, I think, and that is to upgrade this nursery.
Because without that, we really don't have a great chance of succeeding in the overall reduction of infant mortality and maternal mortality in this hospital complex.
These first slides you see are babies in the nursery.
The baby you're looking at right now has sepsis.
The baby you saw just before this has sepsis.
The mother has sepsis as well.
She is being treated but she's not completely well.
Yet in this small room there are nine babies and nine mothers caring for these babies many who have infectious conditions, including the mothers.
But it is clearly crowded.

The next picture shows an oxygen tank on the left.
A mother holding a baby.
Another baby under the hood.
This is just an oxygen line without humidification.
It has a divider on it like a TV antenna and it just delivers oxygen straight to these two babies.
It has a third channel on it going to a third baby.
You can see that the mothers care for their babies here.
This is obviously not ideal conditions.
The next slide shows you an isolette.
And it doesn't work.
There is an oxygen concentrator sitting in front of it that doesn't work.
There are multiple babies in multiple beds.
Two mothers in one bed.
One baby with an IV.
Another baby with an NG tube.
The baby with the IV is wrapped in blankets and I'm sure the IV is not protected very well in that hand.
Conditions are crowded and not very good.

The next slide just shows you another shot of how babies -- multiple babies and mothers are in each bed.
The next one shows that even more clearly where three babies are in the same bed with three mothers lined up caring for those babies.
The mothers feed the babies through the nasal gastric tubes.

The skill of a neonatologists are fine and they care for the babies, they just don't have adequate equipment.
With really some basic equipment here, nursery isolettes.
They have one bili light.
If it was upgraded they would do well with the babies.
Just to end with a couple of nice pictures.
This is a prenatal clinic and a well baby clinic on the outskirts of Kabul.
These are the mothers waiting in line outside the clinic to enter the clinic and they've come for either prenatal visits, post natal visits, immunizations.
Well baby checks or screening if the baby has a cold or something like this.
This is a newly-remodeled clinic being run by one of the NGO's in Afghanistan and one that we would actually like to work with.
The last shot shows two of the mom and two of the really pretty babies getting immunizations and well baby checks.
One thing I would like to say is the babies are very bright-eyed, pretty, clean.
They have wonderful spirit, as do the people.
Very encouraging to know that whatever we do there is going to be appreciated, the people are going to make use of it, the people want it, the people are encouraged by it and the people have enough spirit and energy I think they will make a success of it.

It was fun for me to be able to share this experience with you which is going to become an ongoing experience.
It is what caused me to miss AMCHP and may cause me to miss a meeting or two in the future as this clinic develops.
I think you'll hear more in the media over the next couple of months and I'll be there again, I'm sure, in a month or two depending on what happens in the world as we speak.

So thank you for listening to me and indulging me and letting me share with you these experiences.
If you have questions, we'll hang around for a minute or two and take questions.
Chris, are there any at the moment?

>> No questions at this time.

>> Okay.
Well, I want to thank you all for attending this 10th in a series of MCH broadcasts.
It's a pleasure for us to be able to chat with you this way.
Want to thank again the Center for the Advancement of Distance Education at the University of Illinois Chicago, School of Public Health for making all this work.

And we'll still continue to introduce other communication strategies this next year and to do other things.
Following today's webcast, as you know, as with the others, they are archived and probably will be archived by the first of next week.
We want you to know if you have suggestions for topics that you would like to hear, if you can e-mail us at info @.
The next broadcast will be on April 10, which is a Thursday at 2:00.
We'll probably discuss the children with special health care needs chart book at that time and go through some of the findings with you of the survey and let you know how we'll distribute and publicize and talk about that.
Don't forget, there is an evaluation page which you can fill out so look at the bottom of your screen and there will be a prompt to fill out the evaluation page.

We really appreciate your attention and cooperation.
Have a wonderful rest of the week and please have a safe rest of the week and think well of our soldiers and American G.I.s and others over in Iraq at the present time putting their lives on the line for the freedom that we all desire and love.
Have a good weekend.
Thanks.